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BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Anne L. Marangoni, D.P.M.** **P.O. Box 815** **Pacific Grove, CA 93950** Podiatric Medicine License No. E-3219 Respondent.	Case No. 1B-2004-159009 **ACCUSATION**

The Complainant alleges:

PARTIES

1. James Rathlesberger (Complainant) brings the Accusation solely in his official capacity as the Executive Officer of the Board of Podiatric Medicine (Board).

2. On or about June 21, 1984, Podiatric Medicine License No. E-3219 was issued by the Board to Anne L. Marangoni, D.P.M. (Respondent), and at all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, said license will expire on August 31, 2005. There is no Board record of previous disciplinary action having been taken against this license.

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JURISDICTION

3. This Accusation is brought before the Board of Podiatric Medicine, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2222 of the Code states that:

"The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

"The California Board of Podiatric Medicine may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in this chapter."

5. Section 2497 of the Code states that:

"(a) The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222.

"(b) The board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the

administrative law judge who presided at the hearing shall be present during the board's consideration of the case and shall assist and advise the board."

6. Section 2234 of the Code provides, in pertinent part, that the Division of Medical Quality, Medical Board of California, shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited, to the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence."

7. Section 725 of the Code states, in part, that:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist. However, pursuant to Section 2241.5, no physician and surgeon in compliance with the California Intractable Pain Treatment Act shall be subject to disciplinary action for lawfully prescribing or

administering controlled substances in the course of treatment of a person for intractable pain."

8. Section 14124.12, subdivision (a), of the Welfare and Institutions Code states that:

"Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

COST RECOVERY

9. Section 2497.5 of the Code provides, in part, that the Board may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay the Board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

FACTS
(Patient C.M.[1])

10. The events alleged herein occurred from in or about May 2001 to in or about July

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1. Initials are used to protect patient privacy. Respondent will be provided with the full name of the patient upon receipt of a request for discovery.

2002, during the time respondent practiced as a Doctor of Podiatric Medicine in or about Pacific Grove, California. The Board received a Report of Settlement (Bus. & Prof. Code, § 801) in the matter in or about June 2004.

11. On or about May 14, 2001, respondent undertook to care for and treat patient C.M., a 60-year-old woman with a longstanding history of rheumatoid arthritis, who had experienced years of fungal infections involving her fingernails, toenails, and pedal web spaces. The patient had tried Sporanox years prior without success. At the time of the initial visit, the patient was taking Paxil, Plaquenil, methotrexate, prednisone and folic acid. C.M. reported a recent episode of interdigital fungus in both 4th interspaces for which she was taking Lotrisone, which helped, but she related having her 5th toe continually swollen. Respondent diagnosed tinea pedis interdigital and onychomycosis of the great and right 5th toe. Respondent debrided the onychomycotic nails and gave C.M. a prescription for Loprox gel.

12. C.M. was next seen on July 31, 2001, when she complained of swelling, pain and redness of the right 5th toe. Respondent diagnosed a severe heloma molle with infection of the right 5th toe, and ongoing onychomycosis. The patient was started on Lamisil tablets, the lesion was debrided, and the patient was given interdigital pads and Zithromax Z-pack for the infection. Respondent's records for C.M. document that on August 13, 2001, a prescription for Kelflex was called into the pharmacy for C.M.

13. On August 22, 2001, the patient was seen by respondent and the heloma molle was treated with silver nitrate and a Silipos ring. X-rays showed rheumatoid arthritis of toes. C.M. was continued on Lamisil and she was given a prescription for Diflucan.

14. Respondent next saw C.M. on August 30, 2001, and noted enlargement of the right 5th toe. The heloma molle was again treated with silver nitrate and a Silipos ring.

15. C.M. next saw respondent on September 7, 2001, at which time respondent noted that the right 5th toe remained inflamed. Necrotic tissue was debrided, and the patient was given a Kenalog injection into the right 5th toe.

16. Respondent next saw C.M. on September 28, 2001, at which time the right 5th toe was again injected with Kenalog. Respondent discussed surgery for the right 5th hammertoe with

the patient, and she prescribed Vicodin and Zithromax Z-pack.

17. Respondent's treatment notes document that on October 12, 2001, she discussed surgery for the hammertoe with the patient, which was planned for November 15, 2001.

18. C.M. was next seen on October 30, 2001, after developing an ulcer in the right 5th toe. Respondent injected the toe with Kenalog and the patient was started on Keflex. The records do not document that a gram stain or wound culture was obtained.

19. On November 5, 2001, respondent again injected C.M.'s toe with Kenalog, and she was continued on antibiotics.

20. On November 15, 2001, respondent performed, in the office, an anthroplasty of C.M.'s right 5th toe proximal phalanx and excision of the ulcer by the 4th and 5th toe syndactylism. The dressings were changed on November 19, 2001.

21. C.M. was next seen on November 26, 2001, at which time the sutures were removed and respondent noted that there was a wound dehiscence. Local wound care was provided. Two days later, on November 28, 2001, a refill of a Zithromax Z-pack was prescribed. The records do not document that a gram stain or wound culture was obtained.

22. Respondent next saw C.M. on December 3, 2001. Respondent diagnosed a left foot, 3rd interspace neuroma, which was treated with a Dexamethasone corticosteroid injection. On December 5, 2001, the left foot was treated with an Unna boot to reduce swelling and respondent prescribed Vicodin.

23. C.M. was next seen on December 10, 2001, when an X-ray of the left foot was taken, which showed no abnormality. Respondent noted that the anthroplasty was healing well.

24. On December 14, 2001, respondent saw C.M. and noted that left foot edema had decreased. Respondent prescribed an Arch Binder for support and instructed the patient to remain off work until the problem resolved.

25. On December 17, 2001, respondent started C.M. on Keflex, noting that the right foot wound was reddened. On December 24, 2001, respondent noted that the wound was resolving and that post-op X-rays were satisfactory. Keflex was prescribed.

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26. Respondent next saw C.M. on December 26, 2001. At that time, the right 5th toe was edematos. C.M. was next seen by respondent on December 28, 2001, at which time the wound was 4mm diameter. Respondent noted that the patient was not tending to the wound. Vicodin was prescribed.

27. C.M. was next seen by respondent on January 7, 2002. Respondent noted a remnant ulcer on the medial right 5th toe, delayed healing secondary to dehiscence, as well as oral prednisone for rheumatoid arthritis was interfering with healing. The patient was having problems keeping the foot dressed and was unable to work because of continued swelling on the left forefoot. Respondent prescribed Vicodin.

28. Respondent next saw C.M. on January 15, 2002, at which time respondent noted that the ulcer on the right foot was closing nicely. On January 22, 2002, C.M. was seen with a complaint of swelling. Respondent noted that the patient is active and working full-time. Swelling was not significant on examination.

29. Respondent next saw C.M. on January 30, 2002, when examination revealed the right 5th toe was swollen and painful with an ulcer but no erythema. Respondent gave the patient a Kenalog injection and prescribed Vicodin. The records do not document that an X-ray was taken as a result of the change in status of the toe.

30. C.M. was next seen by respondent on February 4, 2002, at which time the right 4th toe was injected with Dexamethasone phosphate. Respondent noted that the ulcer was not erythematous. On February 11, 2002, respondent noted that there was a satisfactory result from the injection and that the patient would be scheduled for an additional injection "on Friday." On February 15, 2002, respondent injected the right 5th toe with Dexamethasone phosphate. Respondent noted that the left forefoot had improved.

31. Respondent's records for C.M. document a telephone call with C.M. on February 20, 2002, at which time the patient expressed concern regarding possible osteomyelitis. Respondent ordered a CBC. The patient was seen on February 22, 2002, and respondent noted the right 5th toe was less swollen. The CBC test was normal. The right 5th toe was injected with Dexamethasone phosphate. Respondent noted that most of it came out through the ulcer in the

right 5th toe.

32. On February 28, 2002, C.M. was given another injection of Dexamethasone phosphate by respondent where, again, most of it came out through the ulcer. Respondent noted that the patient was on 5 mg. of prednisone and that this interferes with healing.

33. Despite the injections, the right 5th toe remained swollen. C.M. was seen by respondent on March 8, 2002. Respondent advised the patient to continue local wound care and she started the patient on a Zithromax Z-pack. Respondent advised the patient to change prednisone to 2.5 mg. daily. The records do not document that an X-ray was taken, though indicated due to the lack of improvement.

34. C.M. was next seen by respondent on March 15, 2002, at which time respondent noted that the patient had improved on the Zithromax Z-pack and decreased prednisone. The ulcer was treated with silver nitrate. On March 20, 2002, the patient was seen and respondent noted that the right 5th toe was reddened. Culture and sensitivity (C&S) from the ulcer was obtained. Gram stain was positive with cocci and the culture showed 2+ Beta Strep Group B. Respondent prescribed Augmentin.

35. On March 26, 2002, respondent saw C.M. and noted that the ulcer had closed (nearly 19 weeks after the surgery). The patient was given a prescription for Diflucan to begin after she finished the Augmentin. The patient was next seen by respondent on April 9, 2002, at which time respondent noted no redness, but edema remained. The previous ulcer site was treated with silver nitrate. Respondent noted there was no longer a skin break. Augmentin and Diflucan were repeated.

36. C.M. was next seen by respondent on April 22, 2002. The patient expressed strong feelings that her longstanding 5th toe swelling was due to an infection. The patient advised respondent that she was on 5 mg. prednisone and respondent asked her to decrease the dosage.

37. Respondent's records for C.M. document a telephone call respondent had with C.M. on April 25, 2002, wherein respondent noted that the interdigital space had cracked open again and that the patient wanted more Augmentin. C.M. also reported that she had no pain in the toe and that she was able to wear regular shoegear. A prescription for Augmentin was

telephoned in for C.M.

38. Respondent next saw C.M. on May 2, 2002, at which time she prepared a complete summary of treatment provided, explaining the medications prescribed, the patient's strong affect, questionable compliance, exacerbations and remissions of inflammation. Respondent reported that the C&S of March 20, 2002, grew Beta Strep, Group B, and that the patient was put on Augmentin, did well, and that the wound completely closed by April 9, 2002. Respondent noted that on examination on May 2, 2002, the ulcer had re-opened and that for the first time since January 20, 2002, the patient complained of discomfort in the digit. X-rays of the right foot revealed demineralization and bone destruction at the intermediate phalanx as well as at the head of the proximal phalanx at the right 5th toe. Respondent diagnosed osteomyelitis v. rheumatoid arthritis as the cause. Respondent sent baseline and current X-rays to C.M.'s rheumetologist, Dr. Jerry Ginsburg, for opinion, referred the patient to an orthopedist for a second opinion, and attempted consultation with an infectious disease specialist. Respondent debrided necrotic tissue from the right fourth interspace without bleeding.

39. C.M. was next seen by respondent on May 3, 2002, at which time respondent documented the patient reported that her toe felt much better, with no pain following debridement. A bone biopsy was obtained. The patient reported that she had not made an appointment with an orthopedist because it would take too long. Vicodin was prescribed.

40. Respondent's records document that on May 6, 2002, the laboratory reported by telephone that C.M.'s aerobic bone culture had shown no growth, but that the lab did not run the requested anaerobic culture.

41. Respondent's records document that on May 7, 2002, respondent received the report from the laboratory regarding C.M. The bone culture showed no growth. C&S from the ulcer site revealed 3+ Staph epidermidis and 3+ diphtheroids. Respondent documented consultation with C.M.'s rheumatologist, Dr. Ginsburg, who was of the opinion that the patient had osteomyelitis in view of the rapid bony destruction in a short period within only one joint and he ruled out rheumatoid arthritis as a cause. Dr. Ginsburg recommended that respondent consult with Dr. Allen Radner, an infectious disease specialist.

Respondent documented consultation with Dr. Radner who gave several treatment options based on a poor prognosis to cure the osteomyelitis: 1) I.V. antibiotics for four to six weeks followed by 2 months of oral antibiotics; 2) wait three weeks without antibiotics and then re-biopsy the bone; and, 3) amputate the toe.

Respondent examined the patient the same day and it was decided that the patient would wait three weeks without antibiotics and then a re-biopsy would be done.

42. Respondent next saw C.M. on May 31, 2002, at which time another biopsy was obtained, and X-rays showed further destruction of the 5th intermediate phalanx. Gram smear results revealed 2+ WBC, 4+ RBC, 1+ Gram positive Cocci. Vicodin, prescribed on May 16, 2002, was refilled on this date.

43. C.M. was next seen by respondent on June 4, 2002. Lab results of the bone biopsy revealed 1+ Staphylococcus epidermidis. Respondent prescribed Lamisil. The patient was referred to Dr. Allen Radner, an infectious disease specialist, on June 7, 2002.

44. Respondent's records document consultation with Dr. Radner on June 13, 2002, wherein Dr. Radner proposed three options for C.M.'s osteomyelitis: 1) 6 weeks of IV antibiosis with Vancomycin and 3 months of PO antibiosis; 2) amputation of the right 5th toe; and, 3) oral antibiosis. On June 14, 2002, respondent discussed with C.M. the options offered by Dr. Radner and C.M. decided to try IV antibiosis followed by PO antibiosis.

45. C.M. was next seen by respondent on July 15, 2002, when the patient had been on IV Vancomycin through a PIC line under the direction of Dr. Radner for several weeks, with two weeks to go, then three months of oral antibiosis. The patient reported that her 60-lb. dog stepped on her right 5th toe and caused trauma three days ago. Respondent noted that the toe was reddened and swollen several times normal size, only slightly sensitive to touch. X-rays showed no change in bony resorption. Respondent recommended ice packs alternated with heat, elevation of the right foot and time off work and return in two weeks. The following day, July 16, 2002, respondent called in a refill for Vicodin for the patient.

46. Respondent's records document a telephone call with C.M. on July 19, 2002, wherein the patient reported that the PIC line had come out, but was re-inserted at the hospital.

Respondent documented another conversation with the patient on July 22, 2002, wherein the patient reported that the toe was less swollen. This is the last notation in respondent's treatment records for patient C.M.

47. On or about June 25, 2004, the Board received a Report of Settlement, pursuant to Business and Professions Code section 801, indicating that a civil settlement had been reached on respondent's behalf with patient C.M. arising from the amputation of the patient's right 5th toe following care and treatment by respondent.

FIRST CASE FOR DISCIPLINE
(Gross Negligence, Repeated Negligent Acts, Incompetence)

48. The allegations of paragraphs 10 through 47, inclusive, are incorporated herein by reference as if fully set forth.

49. Respondent's license to practice medicine is subject to disciplinary action under Business and Professions Code section 2234 for unprofessional conduct pursuant to subsections (b) gross negligence; (c) repeated negligent acts; and/or (d) incompetence, through sections 2222 and 2497, by reason of the following acts or omission:

A. Respondent failed to follow the standard of care in the evaluation and treatment of the patient's infections. For example:

1. Respondent failed to recognize that C.M., having a history of rheumatoid arthritis and on several medications, including Paxil, Plaquenil, methotrexate, prednisone, and folic acid, would be immunocompromised.

2. Respondent failed to timely seek additional medical opinions. The standard of practice relative to seeking timely additional medical opinions is based upon a failure to produce successful results within a reasonable time frame with treatment provided. Since the onset of C.M.'s symptoms, 10 months passed before respondent sought consultation with C.M.'s rheumatologist and an infectious disease specialist.

3. When C.M.'s wound failed to respond to the treatment regimen of steroid injections and oral antibiotics, respondent failed to timely obtain appropriate

testing, such as gram stain, culture with sensitivity, X-rays, MRI and/or bone biopsy.

B. Respondent failed to follow the standard of care in the treatment of an open wound and infected area by use of repeated injections of steroids. Steroids, oral or injectable, limit inflammation. Injections into an infected area may mask or reduce clinical signs and symptoms of infectious process, and thus delay appropriate diagnosis and treatment. Steroids may exacerbate the infectious process and lead to substantially greater tissue destruction than might otherwise occur. Respondent departed from the standard of care when she: 1) gave an accumulation of four sizable steroid injections into the right 5th toe during September to November 2001; and, 2) gave a series of four steroid injections into the same open wound area in February 2002, after the November 15, 2001, 5th digital medial exostectomy and syndactylism when the 4th webspace dehisced and became ulcerated.

C. Respondent failed to recognize the fact that the patient did not consistently feel significantly better after the preoperative and postoperative series of steroid injections and that the 5th toe problem was more than just arthritic inflammation.

50. Respondent's acts or omissions as set forth above considered singly, jointly, or in any combination thereof, constitute gross negligence, and/or repeated negligent acts, and/or incompetence under Section 2234(b), and/or (c), and/or (d), through Sections 2222 and 2497, and therefore cause for discipline exists thereunder.

SECOND CAUSE FOR DISCIPLINE
(Excessive Treatment)

51. The allegations of paragraphs 10 through 47, inclusive, are incorporated herein by reference as if fully set forth.

52. Respondent's license to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, through sections 2222 and 2497, for unprofessional conduct pursuant to Section 725 by reason of respondent's excessive use of steroids in the care and treatment of patient C.M.

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PRAYER

WHEREFORE, the Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Podiatric Medicine issue a decision:

1. Revoking or suspending Podiatric Medicine License No. E-3219, heretofore issued to respondent Anne L. Marangoni, D.P.M.;

2. Ordering respondent to pay the Board of Podiatric Medicine the actual and reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as deemed necessary and proper.

DATED: June 21, 2005.

JAMES RATHLESBERGER
Executive Officer
Board of Podiatric Medicine
State of California
Complainant